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November 14, 2016

Via United States First Class
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Jeffrey W. Young, Jr., R.N., A.P.R.N.
162 Murray Guard Drive
Jackson, TN 38305

CARE OF:
Christopher Hayden, Esq.
Purcell, Sellers & Craig, Inc.
45 Murray Guard Drive
P.O. Box 10547
Jackson, TN 38308

Re: Jeffrey W. Young, Jr., R.N., A.P.R.N., License Nos. 106598 (R.N.) and 7239 (A.P.R.N.), before the Tennessee Board of Nursing, TENN. CODE ANN. § 4-5-320(c) Notification and Consent Order in Lieu of Formal Proceedings, Case Numbers 2016000671, 2016028221, and 2016043961

Dear Mr. Young:

I serve as Assistant General Counsel for the State of Tennessee, Department of Health (the "Department"). This letter is written pursuant to TENN. CODE ANN. § 4-5-320(c) to advise you that the Department intends to initiate administrative proceedings against you before the Tennessee Board of Nursing (the "Board") which may affect your license to practice as a Registered Nurse and as an Advanced Practice Registered Nurse in Tennessee.

The Department has received complaints against your license. The Department's investigation reviewed your prescribing practices at PreventaGenix. The investigation revealed, among other things, that you inappropriately overprescribed controlled substances, frequently prescribed dangerous combinations of controlled substances, and inadequately charted your patients' office

visits, all of which fall below the standard of care for a Registered Nurse and Advanced Practice Registered Nurse practicing in Tennessee. Specifically, the investigation revealed:

1. From at least February 2013 to the present, you provided treatment to multiple patients as an Advanced Practice Registered Nurse;

2. You are a partial owner of and employed as an Advanced Practice Registered Nurse at PreventaGenix, a family medicine practice in Jackson, Tennessee;

3. As part of your job as an Advanced Practice Registered Nurse at PreventaGenix, you conducted examinations of patients with a variety of ailments and injuries and, in some situations, prescribed medication to those patients, including controlled substances;

4. You may have been operating a noncertified pain management clinic due to a majority of the practice's local, regularly-seen patients having received chronic non-malignant pain treatment;

5. The Department conducted an investigation that included a review of twenty-seven (27) medical records for patients to whom you have prescribed controlled substances;

6. A review of your records indicates that the treatment you provided included prescribing narcotics and other controlled substances in amounts and/or for durations that were not medically necessary, advisable, or justified for a diagnosed condition;

7. You routinely prescribed combinations of controlled substances for your patients without a clear objective finding of a chronic pain source to justify the ongoing and increasing prescribing;

8. You failed to make appropriate, individualized diagnoses and/or failed to document adequate support for diagnoses sufficient to justify the treatment rendered and failed to integrate consultations, previous hospitalizations and other medical information into the treatment plan;

9. You rarely made attempts to identify the etiology of the pain, but rather, treated your patients' complaints;

10. You prescribed controlled substances and other medication without taking a history or inquiring into potential substance abuse history;

11. You prescribed controlled substances and other medications without documenting a written treatment plan with regard to the use of controlled substances and other medication;

12. Your medical records are repetitive, typically indicating no physical examination, a diagnosis based largely on the patient's complaint, and a treatment plan that prescribes drugs, often indefinitely, with unspecified goals for the treatment;

13. You prescribed narcotics and/or other controlled substances to persons when the quantity, duration and method was such that the persons would likely become addicted to the habit of taking said controlled substances, yet you failed to make a bona fide effort to cure the habit of such persons or failed to document any such effort;

14. You habitually prescribed your patients dangerous combinations of medications including opioids and benzodiazepines, and opioids, benzodiazepines, and muscle relaxants, including Carisoprodol;

15. You habitually provided similar narcotic pain management treatment, frequently including hydrocodone, to several of your patients without seeming to have an individualized treatment plan for each particular patient;

16. You failed to properly or consistently monitor for or seek out and respond to signs of substance abuse on the part of your patients;

17. You failed to make appropriate adjustments in your prescribing practices for the purpose of decreasing your patients' addiction habits;

18. You prescribed narcotics and other controlled substances to young, opioid-naive patients without ever discussing the risks, benefits, and addictive qualities of the narcotics and controlled substances;

19. You failed to warn patients about the risks and benefits of the controlled substances being prescribed to them, or about the risks of taking the combinations of controlled substances which you prescribed them;

20. You routinely failed to perform pill counts;

21. You failed to have your patients sign pain agreements prior to treating them with narcotics;

22. You failed to provide alternative modalities of treatment other than the prescription of controlled substances;

23. You repeatedly failed to discuss repetitive inconsistencies in patients' urine drug screens ("UDS"), including those drug screens that were negative for prescribed controlled substances and/or positive for THC and other non-prescribed medications and substances, and you failed to adjust your prescribing behavior for such UDS inconsistencies;

24. You failed to make appropriate referrals to patients for their medical needs and instead continued overprescribing them narcotics and controlled substances;

25. You failed to check your patients' prescription history in the Tennessee Controlled Substance Monitoring Database ("CSMD");

26. You failed to update your practitioner profile in the CSMD to include a supervising physician;

27. You failed have your supervising physician review at least twenty percent (20%) of your patients' medical charts, and you failed have your supervising physician review one hundred percent (100%) of the charts when you prescribed a controlled substance;

28. You failed to have your supervising physician co-sign your patients' charts when you prescribed the patients controlled substances as required by law;

29. You worked without a supervising physician during the month of November 2015, and from May 5, 2016 to the present;

30. You prescribed controlled substances to patients without having approval from your supervising physician before initially prescribing the medication;

31. You prescribed Schedule II and III opioids beyond the maximum of a non-refillable, thirty-day course of treatment without having specific approval after consultation with your supervising physician before initially prescribing the medication;

32. You mislead the public by referring to yourself as Doc, Doctor, and Dr. although you are licensed as an Advanced Practice Registered Nurse and Registered Nurse and you are not a licensed medical doctor; and

33. You contributed to patient MY's prescription drug overdose death.

34. Examples of the behavior described above include, but are not limited to, the following:

    a. You saw patient AD, who was 26 years old at the start of treatment, at PreventaGenix from November 2014 to at least February 2016. AD's charts fail to state a patient complaint, other than that AD requested medication refills. You failed to conduct adequate physical examinations of the relevant areas to support prescribing AD controlled substances. Despite that you consistently marked that there were no abnormalities discovered during AD's physical examinations, you diagnosed AD with chronic pain syndrome, anxiety, and asthma. You failed to adequately state a specific medical diagnosis or treatment plan. Without ever discussing the risks, benefits, and addictive qualities of narcotic treatment, as well as the dangerous interaction of opioids and benzodiazepines, you prescribed AD oxycodone at the high daily dose of 180 Morphine Equivalent Daily Doses ("MEDD"), in dangerous combination with 1 mg of Xanax taken three times daily. You failed to refer AD to a specialist or offer alternative modalities of treatment for his alleged pain, and you failed to wean AD off the high dosage of narcotic pain medication. You failed to conduct a single pill count throughout AD'S treatment, and there is nothing in AD's charts to show that you checked the Tennessee CSMD. You failed to have your charts co-signed by your supervising physician. Your follow up medical charts provide minimal documentation and merely state that you

refilled AD's prescriptions, or even that you increased the dosage, yet you failed ever provide a medical basis for increasing the dosage. AD's UDS showed inconsistent results on multiple occasions, including being negative for the drugs you prescribed him – oxycodone and Xanax, yet you failed to counsel AD about the unexpected drug screen results.

b. You saw patient MY at PreventaGenix from at least September 2014 to August 2015. During one of MY's first office visits in September 2014, MY complained of low back pain and left arm numbness, and he sought refills of pain medications. Without ever completing a physical examination of the relevant areas, you diagnosed MY with chronic low back pain and anxiety. Without stating an assessment or treatment plan, you refilled MY's medications for Percocet 10 mg three times daily, a total of 45 MEDD, and Valium 10 mg two times daily. You continued prescribing MY Percocet 10 mg three times daily and Valium 10 mg two times daily for several months without performing physical examinations to provide a basis for the prescribed drugs. The Tennessee CSMD shows that you also prescribed MY Hydrocodone, at times along with the Percocet; however MY's medical charts fail to show a reason for the additional pain medication. Throughout your treatment of MY, you failed to conduct pill counts, failed to check the CSMD, failed to discuss the risks and benefits of the dangerous combinations of drugs you prescribed, and failed to have MY sign a pain contract.

In March 2015, you state in MY's charts that you were weaning MY's pain medications based upon MY's request. From April 2015 through early August 2015, you did not prescribe MY narcotics. In June 2015, although you failed to note any abnormalities in MY's physical examination, and you failed to state a medical basis or diagnosis for changing and adding to MY's medications, you prescribed MY the dangerous combination of a benzodiazepine and a muscle relaxant: Xanax 1 mg three times daily and Carisoprodol 350 mg three times daily.

On August 3, 2015, when MY was likely opioid naive, while failing to state a diagnosis, assessment, or treatment plan for prescribing MY pain medications again, you prescribed MY Lortab 10/325 mg three times daily along with Clonazepam 1 mg three times daily and Carisoprodol 350 mg three times daily. The Tennessee CSMD shows that on August 10, 2016, MY visited the emergency room where he was prescribed 30 tablets of Tramadol 50 mg and 6 tablets of Acetaminophen with Codeine 300/30 mg.

Immediately following MY's emergency room visit, on August 12, 2015, you again prescribed MY the dangerous combination of Zohydro ER 40 mg two times daily, Clonazepam 1 mg three times daily, and Carisoprodol 350 mg three times daily. During the same office visit on August 12, 2015, MY completed a Do Not Resuscitate ("DNR") Order, which you signed and printed your name as MY's "Attending Physician." Subsequently, on August 25, 2016, MY was discovered deceased in his bedroom at his home. No autopsy was performed, but the Crockett County Medical Examiner opined that MY died of a drug overdose. Immediately

after MY's death, the Crockett County Ambulance Service discovered a used syringe under MY's bedroom pillow, syringes in MY's bedroom closet, empty pill bottles – including Clonazepam, Carisoprodol, and Zohydro ER that were filled in August 2015 – on MY's bedside table, and needle puncture wounds on MY's body. MY's death certificate states that he was found dead due to a probable cardiac event due to polypharmacy, or the simultaneous use of multiple drugs.

c. You saw patient SB at PreventaGenix from February 2015 to January 2016. SB complained of low back pain. You prescribed SB the dangerous combination of Morphine, at the dangerously high dose of 180 MEDD, Xanax, and Carisoprodol. You failed to counsel SB regarding the risks, benefits, and dangerous addictive qualities of the controlled substances being prescribed to her, as well as the dangerous interaction of opiates, benzodiazepines, and muscle relaxants. Your medical charts are inadequate and provide minimal to no documentation concerning relevant physical examinations, assessments, diagnoses, or treatment plans. You failed to conduct pill counts, failed to check the CSMD, failed to have your charts co-signed by your supervising physician, and failed to have SB sign a pain contract. SB's UDS had unexpected results, including being positive for non-prescribed drugs such as Tramadol and Fentanyl, and negative for prescribed drugs, such as Carisoprodol, yet SB's medical charts fail to show that you adequately counseled her about the unexpected drug screen results.

d. You saw patient MN, who was only 12 years old at the start of treatment at PreventaGenix from January 2015 to at least March 2016. MN complained of mood swings and difficulty focusing. Without ever conducting a physical examination to support a medical diagnosis of ADD, you prescribed MN Focalin 10 mg daily, a schedule II controlled substance, to treat ADD. Your medical charts are poor and provide minimal notes for each visit. You failed to conduct adequate physical examinations, failed to state an assessment or treatment plan, and continued to prescribe MN the controlled substance for over a year.

e. You treated patient RR from on or around February 2013 until on or around October 2014. Between February 2013 and April 2014, you wrote RR prescriptions for controlled substances, including multiple prescriptions for Norco, Lortab, Vicodin, Xanax, and Adderall, without ever seeing RR in your office to perform a medical history and a physical examination, or to diagnose him with a condition. You prescribed RR the controlled substance prescriptions based solely on RR's request for the medications. You failed to have any medical charts for RR for several of the months that you wrote him controlled substance prescriptions. You failed to refer him to a specialist for his alleged conditions. You failed to monitor his usage of the controlled substances – such as conducting pill counts, performing UDS, or checking the CSMD. You failed to have RR sign a pain agreement. RR subsequently suffered a stroke in April 2014 and was diagnosed with hypertension. Due to your failure to perform an adequate medical history and physical examination on RR, you never noticed the symptoms of RR's hypertension and instead prescribed him controlled substances that may have exasperated his

symptoms. Despite having prescribed RR multiple controlled substances for over a year, the only medical charts you have for RR are for two office visits in October 2014. During the October 2014 office visits, you failed to conduct an adequate physical examination of the relevant areas, failed to state an assessment or treatment plan, and failed to adequately state a specific medical diagnosis.

These investigatory findings are all in violation of the statutes and rules adopted by the Board and below the standard of care for a Registered Nurse and an Advanced Practice Registered Nurse practicing in Tennessee. The patients at issue are as follows (initials are listed to maintain confidentiality): MA, EA, HA, SB, AB, RC (dob 4/12/1960), CC, RC (dob 1/15/1987), AD, CD, ED, JD, HD, JE (dob 6/14/1949), JE (dob 4/2/1977), VF, KH, DK, RM, DN, MN, RN, RR, SS, JT, DT, and MY.

The Department contends that you are in violation of the Tennessee Nursing Practice Act, found at TENN. CODE ANN. § 63-7-101 *et seq.* TENN. CODE ANN. § 63-7-115 gives the Board the power to deny, suspend, or revoke the license of, or to otherwise lawfully discipline, a licensee who is guilty of violating any of the provisions of the Tennessee Nursing Practice Act. The relevant sections of the TENN. CODE ANN. and Rules and Regulations promulgated by the Board of Nursing, which you have violated by these acts or omissions include, but are not limited to the following:

(1) TENN. CODE ANN. § 63-7-115(a)(1)(C), which states that the "board has the power to deny, revoke or suspend any certificate or license to practice nursing or to otherwise discipline a licensee upon proof that the person:"

Is unfit or incompetent by reason of negligence, habits or other cause.

(2) TENN. CODE ANN. § 63-7-115(a)(1)(F), which states that the "board has the power to deny, revoke or suspend any certificate or license to practice nursing or to otherwise discipline a licensee upon proof that the person:"

Is guilty of unprofessional conduct.

(3) TENN. CODE ANN. § 63-7-123(b)(2)(B):

(B) Notwithstanding subdivision (b)(2)(A), a nurse practitioner shall not prescribe Schedules II, III and IV controlled substances unless such prescription is specifically authorized by the formulary or expressly approved after consultation with the supervising physician before the initial issuance of the prescription or dispensing of the medication.

(4) TENN. CODE ANN. § 63-7-123(b)(2)(C):

(C) A nurse practitioner who had been issued a certificate of fitness may only prescribe or issue a Schedule II or III opioid listed on the formulary for a maximum of a non-refillable, thirty-day course of treatment unless specifically

approved after consultation with the supervising physician before the initial issuance of the prescription or dispensing of the medication.

(5) TENN. CODE ANN. § 63-7-123(b)(3)(A), which requires that,

Every prescription issued by a nurse practitioner pursuant to this section shall be entered in the medical records of the patient and shall be written on a preprinted prescription pad bearing the name, address and telephone number of the supervising physician and of the nurse practitioner, and the nurse practitioner shall sign each prescription so written.

(6) TENN. COMP. R. & REGS. Rule 1000-01-.13(1)(b):

Failure to maintain a record for each patient which accurately reflects the nursing problems and interventions for the patient and/or failure to maintain a record for each patient which accurately reflects the name and title of the nurse providing care.

(7) TENN. COMP. R. & REGS. Rule 1000-01-.13(1)(r):

Failing to take appropriate action in safeguarding the patient from incompetent health care practices.

(8) TENN. COMP. R. & REGS. Rule 1000-01-.13(1)(t):

Over-prescribing, or prescribing in a manner inconsistent with Rules 1000-04-.08 and 1000-04-.09.

(9) TENN. COMP. R. & REGS. Rule 1000-01-.13(1)(u):

Practicing professional nursing in a manner inconsistent with TENN. CODE ANN. § 63-7-103.

(10) TENN. CODE ANN. § 63-7-103(a)(2): "Professional nursing" includes:

(A) Responsible supervision of a patient requiring skill and observation of symptoms and reactions and accurate recording of the facts;

(C) Counseling, managing, supervising and teaching of others;

(F) Nursing management of illness, injury or infirmity including identification of patient problems.

(11) TENN. COMP. R. & REGS. Rule 1000-01-.13(1)(w):

Engaging in acts of dishonesty which relate to the practice of nursing.

(12) TENN. COMP. R. & REGS. Rule 1000-04-.08, which provides guidelines to determine whether an Advanced Practice Registered Nurse's conduct violates TENN. CODE ANN. § 63-7-115(a)(1)(A) through (G) in regard to the prescribing, administering, ordering, or dispensing of pain medications and other drugs necessary to address their side effects.

(13) TENN. COMP. R. & REGS. Rule 0880-06-.02(5) and (6), which enumerates protocols that are required between a supervising physician and nurse practitioner.

(14) TENN. COMP. R. & REGS. Rule 0880-06-.02(7), which requires a nurse practitioner's supervising physician to do the following:

(7) Once every ten (10) business days the supervising physician shall make a personal review of the historical, physical and therapeutic data and shall so certify by signature on any patient within thirty (30) days:

(a) When medically indicated;

(b) When requested by the patient;

(c) When prescriptions written by the certified nurse practitioner fall outside the protocols;

(d) When prescriptions are written by a nurse practitioner who possesses a temporary certificate of fitness; and

(e) when a controlled drug has been prescribed.

(15) TENN. COMP. R. & REGS. Rule 1000-04-.09(1), which provides that it shall be a prima facie violation of TENN. CODE ANN. § 63-7-115(a)(1)(C) and (F) for an Advanced Practice Nurse, having proper authority to prescribe, to prescribe or dispense any drug to any individual, whether in person or by electronic means or over the Internet or over telephone lines, unless the Advanced Practice Nurse with proper authority to prescribe or the A.P.N's licensed supervisee and pursuant to appropriate protocols or orders, has completed and appropriately documented, for the person to whom a prescription is to be issued or drugs dispensed, all of the following:

(a) Performed an appropriate history and physical examination; and

(b) Made a diagnosis based upon the examinations and all diagnostic and laboratory tests consistent with good health care; and

(c) Formulated a therapeutic plan, and discussed it, along with the basis for it and the risks and benefits of various treatments options, a part of which might be the prescription or dispensed drug, with the patient; and

(d) Insured availability of the Advanced Practice Nurse with proper authority to prescribe, or coverage for the patient for appropriate follow-up care.

(16) TENN. CODE ANN. § 63-1-301(8)(A) defines a "Pain management clinic" as a privately-owned clinic, facility or office in which any health care provider licensed under this title provides chronic non-malignant pain treatment to a majority of its patients for ninety (90) days or more in a twelve-month period.

(17) TENN. CODE ANN. § 63-1-306(c)(1):

(1) Every pain management clinic shall submit an application to the department on a form prescribed by the department for a certificate to operate the clinic. A certificate may be awarded to a certificate holder. The certificate holder shall be one (1) of the owners of the clinic.

The Department contends that your conduct constitutes grounds for the discipline of your license. If you disagree, then you may, pursuant to TENN. CODE ANN. § 4-5-320(c), contact me to set up a conference in order to give you an opportunity to show compliance with all lawful requirements for the retention of your license. If you do not respond or are unable to show that you are in compliance, then the Department will file a formal Notice of Charges against your license and a formal contested case hearing—a trial—will take place before the Board.

If you cannot show compliance and you want to settle this case now without further proceedings, then please read the enclosed proposed Consent Order. If you agree with the Consent Order, then sign and date the Consent Order, and return the original to my office by the due date: **Friday, December 9, 2016**. The Department will submit the signed Consent Order to the Board for approval. If the Board approves the Consent Order, then you will be mailed a copy of the Consent Order as ratified by the Board. If the Board does not approve the Consent Order, then the Department will notify you and will file a formal Notice of Charges against you. This offer to settle the case by Consent Order will expire on **December 9, 2016**. Should this matter go to a contested case hearing, all the above allegations and grounds may be presented to the Board.

Again, if the Department does not receive any response from you by the Due Date, the Department will file formal disciplinary charges and present the case at a contested case hearing—a trial—before the Board. At the hearing, the Board may impose penalties and costs more severe than those in the Consent Order. In addition, the several hundred dollar cost of filing a Notice of Charges will likely be assessed against you.

Thank you for your prompt attention to this matter. You may wish to consult legal counsel regarding your decision. **Please contact me at (615) 253-9954 if you have any questions.**

Sincerely,

Tracy L. Alcock
Assistant General Counsel
Tennessee Department of Health

Enclosure:
Consent Order: **Due Friday, December 9, 2016**